Commonwealth of Massachusetts
Executive Office of Health and Human Services

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Companion Guide

Health-Care Claim: Institutional

For ASC X12N 837 (version 4010A1)

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1.0 Introduction

1.1 What Is HIPAA?

The Health Insurance Portability and Accountability Act of 1996 — Administrative Simplification (HIPAA-AS) requires that MassHealth and all other health insurance payers in the United States comply with the electronic data interchange standards for health care as established by the Secretary of Health and Human Services (HHS). HHS has adopted an Implementation Guide for each standard transaction. Version 0004010X096A1 of the 837 Institutional transaction is the standard established by HHS for institutional claims submission.

1.2 Purpose of the Implementation Guide

The Implementation Guide for the 837 Institutional claim transaction specifies in detail the required formats for claims submitted electronically to an insurance company, health-care payer, or government agency. The implementation guide contains requirements for use of specific segments and specific data elements within the segments, and was written for all health-care providers and other submitters. It is critical that your software vendor or IT staff review this document carefully and follow its requirements to submit HIPAA-compliant files to MassHealth.

1.3 How to Obtain Copies of the Implementation Guides

The 837I implementation guides for X12N 837I version 4010A1 and all other HIPAA standard transactions are available electronically at www.wpc-edi.com/HIPAA.

1.4 Purpose of This Companion Guide

This 837I Companion Guide was created for MassHealth trading partners by MassHealth to supplement the 837I Implementation Guide. It contains MassHealth-specific instructions for the following:

- data content, codes, business rules, and characteristics of the 837I transaction;
- technical requirements and transmission options; and
- information on testing procedures that each trading partner must complete before submitting 837I claims.

The information in this guide supersedes all previous communications from MassHealth about this electronic transaction. The following policies are in addition to those outlined in the MassHealth provider manuals for individual claim types. These policies in no way supersede MassHealth regulations. This companion guide should be used in conjunction with the information found in your MassHealth provider manual.

1.5 Intended Audience

The intended audience for this document is the technical staff responsible for submitting electronic 837I claims to MassHealth. In addition, this information should be shared with the provider's billing office to ensure that all required billing information is available for claim submission.

2.0 Establishing Connectivity with MassHealth

All MassHealth trading partners must sign a Trading Partner Agreement (TPA) and will be requested to complete a trading partner profile (TPP) form before submitting electronic 837 transactions. Note that TPP information may be given over the telephone in lieu of completing a paper form. If you have already completed these forms, you do not have to complete them again. Please contact MassHealth Customer Service at 1-800-841-2900 (See Section 2.5 - Support Contact Information) if you have any questions about these forms.

2.1 Setup

MassHealth trading partners should submit HIPAA 837I claims to MassHealth via the transactions Web site or, if necessary, on hard media (for example, CD-ROM). Trading partners must contact MassHealth Customer Service at 1-800-841-2900 with questions about these options.

After establishing a transmission method, each trading partner must successfully complete testing. Information on this phase is provided in the next section of this companion guide (See Section 2.2 - Trading Partner Testing). After successful completion of testing, 837I transactions may be submitted for production processing.

All hard media (testing and production claims) must prominently display the file name on the label, along with the identifying information described below. The external label on the hard media must appear as follows:

Header:	*MassHealth Submission*
File Name:	*As determined by the submitter following the appropriate file-naming convention for test or production claims*
Transaction Type:	*Institutional*
MassHealth Submitter/ Pay-to-Provider number:	*The MassHealth number of the provider or billing intermediary submitting the hard media*
Submitter Name:	*The name of the provider or billing intermediary submitting the hard media*
Submission Date:	*MM/DD/YY*
Contact Name:	*The name of the person to contact if MassHealth has a problem with the hard media*
Contact Information:	*Telephone number and/or e-mail address*

2.2 Trading Partner Testing

Before submitting live 837 claims to MassHealth, each trading partner must be tested. All trading partners who plan to submit 837I transactions must contact MassHealth Customer Service at 1-800-841-2900 in advance to discuss the testing process, criteria, and schedule. Trading partner testing includes HIPAA compliance testing as well as validating the use of conditional, optional, and mutually defined components of the transaction.

If you are a current paper submitter or first-time submitter:

- We require a file with a minimum of 10 and a maximum of 50 test claims.
- The member and provider data must be valid for a mutually agreed upon effective date.

The test files should contain as many types of claims as necessary to cover each of your business scenarios.

The following conditions must be addressed in one or more test files:

- original claims;
- void claims (if you plan to submit void claims);
- replacement claims (if you plan to submit void transactions and replacement claims); and
- coordination of benefits claims (COB, if you plan to submit COB claims).

Providers submitting test files containing COB claims (where the member has other insurance) should include a minimum of 10 and a maximum of 50 COB claims with the following criteria:

- claims with commercial insurance (denied/paid);
- claims with Medicare (denied/paid);
- claims with multiple insurance, if applicable; and
- claims with COB overrides, if applicable to the submitter (certain provider types only as described in provider bulletins).

All test files, regardless of the type of services provided, should be submitted using the following naming convention for all media types:

- **T**YYYYYYY.ZZZ, where:
  - **T** is the letter "T" indicating Test data.
  - YYYYYYY is the seven-digit MassHealth Submitter ID/Pay-to-Provider number.
  - ZZZ is the sequence number assigned to the file by the Trading Partner, starting with a value of "001." This sequence number should be increased by one for each subsequent test file that is submitted. The sequence number will restart at 001 after it reaches 999.

Providers are advised to submit the 835 remittance advice and/or the paper explanation of benefits (EOB) from the other insurer to be used in the testing process for verification of data in the COB loops. Providers must indicate which claims on the 835 remittance advice and/or paper EOB correspond to the claims on the test file.

MassHealth will process these transactions in a test environment to validate that the file structure and content meet HIPAA standards and MassHealth-specific data requirements. Once this validation is complete, the trading partner may submit production 837I transactions to MassHealth for adjudication. **Test claims will not be adjudicated.**

2.3 Technical Requirements

The current maximum file size for any 837 file submitted to MassHealth is 16 megabytes. If you are uploading multiple 837 files using the transactions Web site, the maximum is 16 megabytes per upload, not per file. You can also submit your claims in a compressed zip file that contains no more than 99 claim files. If you have questions, contact MassHealth Customer Service at 1-800-841-2900 (See Section 2.5 - Support Contact Information).

MassHealth endorses the ASC recommendation that trading partners limit the size of the transaction (ST-SE envelope) to a maximum of 5,000 CLM segments. There is no recommended limit to the number of ST-SE transactions within a GS-GE or ISA-IEA.

2.4 Acknowledgements

Confirmation numbers are generated for all 837 transaction files uploaded to the Web portal, indicating a successful file upload. 997 functional acknowledgements are generated for all 837 files submitted to MassHealth. These acknowledgements will be available for download from the transactions Web site.

MassHealth uses the tilde (~) segment terminator on all outbound HIPAA-compliant transactions. HIPAA-compliant outbound transactions from MassHealth include the 835 electronic remittance advice transactions and the 997 acknowledgements.

2.5 Support Contact Information

MassHealth Customer Service
Phone: 1-800-841-2900
Fax: 617-988-8971
P.O. Box 9118
Hingham, MA 02043
E-mail: hipaasupport@mahealth.net

All hard media containing claims must be mailed to the above address.

3.0 MassHealth-Specific Submission Requirements

The following information is for production claims. For test claims refer to the Trading Partner Testing section.

The following sections outline recommendations, instructions, and conditional data requirements for 837I claims submitted to MassHealth. This information is designed to help trading partners construct the 837 transactions in a manner that will allow MassHealth to efficiently process claims.

MassHealth expects the provider's national provider identifier (NPI) in the appropriate NM109 data element, and taxonomy code in the appropriate PRV data element, unless you are not required to use an NPI. If you are not required to use an NPI, your MassHealth provider number should be submitted in the appropriate REF02 data element with an REF01 qualifier of 1D.

3.1 Claims Attachments

An electronic standard for claims attachments has not been finalized by the Centers for Medicare & Medicaid Services (CMS). Until then, MassHealth has developed an alternative method for handling electronic claims that require attachments under HIPAA(for example, medical forms, consent forms, etc.). **Note: "**Attachments" does not refer to coordination of benefits (COB) attachments such as an explanation of benefits (EOB). See Section 3.3 - Coordination of Benefits (COB) for more information.

When MassHealth receives a claim requiring an attachment, it is suspended and a claims attachment form (CAF) is mailed to the provider. The CAF contains information relevant to the claim, including but not limited to patient name, MassHealth ID number, date of service, error number, and reason the attachment is being requested. The provider must return the CAF with the required attachment within 45 days of the date on the CAF to the following address.

MassHealth Customer Service
Attention: Claims
P.O. Box 9118
Hingham, MA 02043

The claim will be held in suspense for 45 days to await receipt of the attachment. This time period will not count against the **initial** 90-day billing deadline. Failure to submit attachments with the CAF within 45 days of the date on the CAF will cause the suspended claim to deny for Edit 360: "No response to our CAF."

Until a standard for electronic attachments is finalized by CMS, providers and billing intermediaries submitting HIPAA claims to MassHealth must follow the CAF process to properly adjudicate claims requiring attachments. This does not alter the current method of claim and attachment submission via paper, which will continue to be available to providers.

MassHealth has reviewed its requirements for attachments, and will be allowing the following attachments to be kept on file rather than requiring them to be submitted with the claim or through the CAF process.

If you submit this type of attachment…	and you are this provider type…	you may keep the attachment on file (Code to enter in PWK02)
Certification for Payable Abortion (CPA-2) form	acute inpatient hospital acute outpatient hospital	PWK02 = AA

Please refer to the Detail Data section for instructions on completing the PWK segment.

All attachments not listed above (with the exception of coordination of benefits attachments such as an explanation of benefits) must continue to be submitted, either with a paper claim or via the CAF process.

Periodically, MassHealth may ask providers to verify the completion of attachments kept on file. In cases where MassHealth reviews have revealed provider noncompliance with the recordkeeping requirements of 130 CMR 450.205(A) through (C), MassHealth may pursue any legal remedies available to it, including but not limited to recovery of overpayments and imposing sanctions in accordance with the provisions of 130 CMR 450.234 through 450.260.

3.2 Encounter Claims

MassHealth does not accept encounter claims. For further details, see Section 3.6 - Detail Data.

3.3 Coordination of Benefits (COB)

The implementation of the 837 transaction enables providers to submit claims for members with other insurance electronically to MassHealth, after billing all other resources. Claims where Medicare is the secondary payer or the member has Medicare supplemental insurance must be submitted to MassHealth by the provider. The Centers for Medicare & Medicaid Services (CMS) has consolidated the Medicare claims crossover process by appointing a single Coordination of Benefits Contractor (COBC) by means of the Coordination of Benefits Agreement (COBA) initiative. Under COBA, claims for dually entitled (Medicare/Medicaid) members that have been approved by Medicare will be forwarded electronically to MassHealth by the COBC. For more information about COBA, please refer to the COBA Implementation User Guide located at http://www.cms.hhs.gov/medicare/cob/coba.asp.

When submitting an 837 transaction to MassHealth for members with other insurance, providers must supply the other payer's adjudication details that were provided on the 835 remittance transaction. Providers are required to enter the other payer's adjudication details at the claim level. Line-level adjudication details are required for outpatient, home health, and hospice claims. The adjustment reason codes entered in the COB loops should be the exact codes given by the other payer. Altering the adjudication details given by the other payer is considered fraudulent.

In addition, since the national provider identifier rule has not been finalized, MassHealth requires providers to enter the MassHealth-assigned carrier code on the 837 transaction to identify the other insurance. The MassHealth Recipient Eligibility Verification System (REVS) provides a five-digit insurance carrier code for all applicable insurance coverage for a member.

After billing all resources before billing MassHealth, enter the first three digits of the other payer's carrier code on the 837 transaction. To ensure accurate processing, the three-digit carrier codes entered on the 837 transaction must match the first three digits of the carrier code given by REVS. See Section 3.7 - Detail Data for COB Claims for more details.

3.3.1 COB Bundled Claims

MassHealth will process claims for services that are bundled by a commercial insurance or Medicare as a bundled claim. If you need to correct a bundled claim, you must void all paid service lines associated with the bundled claim, make the necessary corrections to the claim, and resubmit the bundled claim as an original 837 transaction.

3.4 Void Transactions

Please Note: Under HIPAA guidelines, adjustments to paid claims should be submitted as void/replace transactions.

Void transactions are used by submitters to correct and report any one of the following situations:

- duplicate claims erroneously paid;
- payment to the wrong provider;
- payment for the wrong member;
- payment for overstated or understated services; and
- payment for services for which payment has been received from third-party payers.

Void transactions must be submitted for one service line at a time to accommodate MassHealth processing rules. For example, if a provider wishes to void out a claim that was originally submitted with three service lines, the provider would have to submit three void transactions. Each transaction would be for one of the service lines and must include the original MassHealth-generated transaction control number (TCN) for the service as the "Former TCN" with a claim frequency code equal to "8."

3.5 Production File-Naming Convention

837 files transmitted to MassHealth using the Web site may use any convenient file-naming convention. The system will rename files upon receipt and issue a tracking number for reference. 837 files transmitted to MassHealth via hard media must adhere to the following naming convention:

- **H**YYYYYYY.ZZZ, where:
  - **H** is the letter "H," which indicates a HIPAA-compliant production file.
  - YYYYYYY is the seven-digit MassHealth Submitter/Pay-to-Provider number.
  - ZZZ is the sequence number assigned to the file starting with a value of "001." The sequence number should be increased by one for each subsequent file that is submitted. The sequence number will restart at 001 after it reaches 999.

3.6 Detail Data

Although submitters can view the entire set of required data elements in the 837I Implementation Guide, MassHealth recommends that submitters pay special attention to the following segments as these segments have already generated questions.

Loop	Segment		Element Name	Companion Information
----	ISA	05	Interchange sender ID qualifier	Enter "ZZ."
----	ISA	06	Interchange sender ID	Enter your seven-digit MassHealth provider number. Please note, do not enter a National Provider Identifier (NPI) here.
----	ISA	07	Interchange receiver ID qualifier	Enter "ZZ."
----	ISA	08	Interchange receiver ID	Enter "DMA7384."
----	ISA	15	Interchange usage indicator	This element is used to indicate whether the transmission is in a test or production mode. A "P" indicates production data, and a "T" indicates test data.
----	GS	02	Application sender's code	Enter your seven-digit MassHealth provider number.
----	GS	03	Application receiver's code	Enter "DMA7384."
----	BHT	06	Transaction type code	In the Beginning of Hierarchical Transaction (BHT) loop, BHT06 should always be equal to "CH," and all submitted 837 transactions should be claims for payment. A set of encounters, indicated by BHT06 equal to "RP," will pass compliance checks but no transactions within the set will be released to the adjudication system.
1000A	NM1	09	Submitter identification code	Enter your seven-digit MassHealth provider number.
1000B	NM1	09	Receiver identification code	Enter "DMA7384."

Loop	Segment		Element Name	Companion Information
2000B	SBR	09	Subscriber information claim filing indicator code	Enter ”MC.”
2010BA	NM1	09	Subscriber name/identification code	10-character MassHealth member’s identification number (RID) when NM108 is ”MI” and NM102 is “1”
2300	CLM	05-1	Claim information Facility code value (facility type code)	The 837I format uses the first two characters of Bill Type to establish place of service for the entire claim.
2300	REF	01/02	Prior authorization or referral number	If prior authorization exists, enter ”G1” in REF01 and enter the MassHealth assigned six-character prior-authorization number in REF02. (Also see 2400 REF01/REF02 Prior authorization or referral number.)
2300	REF	01/02	Prior authorization or referral number	Enter ”9F” in REF01 and the PCC’s seven-digit referral number in REF02 if the member you are billing for is enrolled in a PCC Plan and all services being billed for require PCC authorization. (Also see 2400 REF01/REF02 Prior authorization or referral number.)
2300	REF	01/02	Original reference number/reference identification	If submitting a void or replace transaction, enter ”F8” in REF01 and the 10-character transaction control number (TCN) from the original claim.
2300	REF	01/02	Preadmission screening reference number	If preadmission screening is required for this claim, enter ”G4” in REF01 and the assigned six-digit preadmission screening number in REF02.
2300	AMT	01/02	Patient estimated amount due	If there is a patient paid amount associated with the services provided, enter ”F3” in AMT01 and the amount of the patient paid amount in AMT02.
2300	PWK	01	Report type code	This code indicates the title of a document, report, or supporting information to be submitted separately. Enter date and time of each visit on claims.

Loop	Segment		Element Name	Companion Information
2300	PWK	02	Report transmission code	Enter “AA” (available on request at provider site). Claims submitted with a transmission code of “AA” will notify MassHealth that the attachment is one of the approved attachments allowed to be kept on file at the provider’s office. Enter date and time of each visit on claims.
2300	HI	01-1, 02-1, 03-1, 04-1, 05-1, 06-1, 07-1, 08-1, 09-1, 10-1, 11-1, 12-1	Claim information/occurrence span information Code list qualifier code	If you are reporting medical or nonmedical leave days, enter ”BI” here. This field allows for up to three separate occurrences of medical or nonmedical leave days.
2300	HI	01-2, 02-2, 03-2, 04-2, 05-2, 06-2, 07-2, 08-2, 09-2, 10-2, 11-2, 12-2	Claim information/occurrence span information Industry code (occurrence span code)	Enter “X0” here to indicate medical leave days. Enter “X1” to indicate nonmedical leave days.
2300	HI	01-3, 02-3, 03-3, 04-3, 05-3, 06-3, 07-3, 08-3, 09-3, 10-3, 11-3, 12-3	Claim information/occurrence span information Date time period format qualifier (occurrence span code associated date)	If you are indicating medical or nonmedical leave days, enter the start date.
2300	HI	01-4, 02-4, 03-4, 04-4, 05-4, 06-4, 07-4, 08-4, 09-4, 10-4, 11-4, 12-4	Claim information/occurrence span information Date time period (occurrence span code associated date)	If you are indicating medical or non-medical leave days, enter the end date.
2300	HI	01-2, 02-2, 03-2, 04-2, 05-2, 06-2, 07-2, 08-2, 09-2, 10-2, 11-2, 12-2	Claim information/value information	If you are a rest home or nursing facility provider billing for a member occupying a rest home bed, enter "BE" in the HIXX-1 field, "86" in the corresponding HIXX-2 field, and as indicated in the Implementation Guide, enter your daily MassHealth rate in the HIXX-5 field.
2300	DTP01		Admission Hour and Day	This is required for acute inpatient and outpatient hospitals. Enter the hour the member was admitted for care.

Loop	Segment		Element Name	Companion Information
2400	SV2	01	Product/service ID (revenue code)	If you are billing for home health services (previously billed on a claim form no. 09), enter the appropriate revenue code in the 560, 570, and/or 580 ranges. If you are billing for hospice services (previously billed on a claim form no. 09), enter the appropriate revenue code in the 650 range.

3.7 Detail Data for COB Claims

Loop	Segment		Element Name	Companion Information
2300	CLM	07	Provider accept assignment code	For all crossover claims, MassHealth requires the value of "A." Claims will not pay if the field is not used or is sent with another value.
2330B	NM1	08	Identification code qualifier	Enter "PI" for payer identification.
2330B	NM1	09	Other payer primary identifier	MassHealth-assigned three-digit carrier code when NM108 is "PI" (see Appendix C: Third-Party-Liability Codes in your provider manual or refer to the Provider Library at www.mass.gov for information).
2430	SVD		Service line adjudication information	Required if other payer has adjudicated the service line.
2430	CAS		Service line adjustment	Required if other payer has not paid in full. All adjustment reason codes given by the other payer must be present.

3.8 Additional Information

MassHealth does not process certain loops that do not apply to the MassHealth business model. For example, MassHealth does not process 2000C Patient Hierarchical Level since there is no dependent coverage (all members are subscribers). In certain circumstances, these loops may be required in a compliant 837 transaction. However, the data content of these loops will not affect the MassHealth claims adjudication process.

The loops listed in the table below are not processed.

Hierarchical Level	Loops Not Processed Within HL	Element Name
Header	1000B	Receiver name
2000B Subscriber	2010BB 2010BC 2010BD 2305 2310E 2330D 2330E 2330F 2330H	Credit/debit card account holder name Payer name Responsible party name Home health care plan information Service line facility name Other payer attending provider Other payer operating provider Other payer other provider Other payer service facility provider
2000C Patient	2010CA	Patient name

3.9 Service Codes

Please consult Subchapters 5 and 6 of your MassHealth provider manual for information on acceptable revenue and service codes. This information is also available on the Web.

Home health agency, nursing facility, ICF-MR state school, and rest home providers who previously submitted claims using the MassHealth proprietary electronic formats for the no. 9 and no. 10 claim forms should consult the National Uniform Billing Committee (NUBC) code data for acceptable revenue codes.

Hospice providers must use only those revenue codes found on the list of acceptable codes issued by MassHealth for all claims with dates of service on and after January 1, 2004. The list of acceptable revenue codes was mailed to all hospice providers in December 2003, via Transmittal Letter HOS-12 (December 2003).

4.0 Sample MassHealth Transactions

Example of MassHealth 837I Transaction

ISA*00* *00* *ZZ*9999999 *ZZ*DMA7384 *030228*0934*U*00401*000000003*1*T*:
GS*HC*9999999*DMA7384*20030228*0934*3*X*004010X096A1~
ST*837*30001~
BHT*0019*00*484*20030228*0934*CH~
REF*87*004010X096A1~
NM1*41*2*MEDICAL CLAIMS*****46*9999999~
PER*IC*JANE DOE*TE*8605551124*FX*8605551146~
NM1*40*2*MA MEDICAID*****46*DMA7384~
HL*1**20*1~
PRV*PE*ZZ*103T00000X~
NM1*85*2*BILLING AGENT*****24*123456789~

Example of MassHealth 837I Transaction (cont.)

N3*345 ZERO DRIVE~
N4*ANDOVER*MA*01810~
REF*1D*9812345~
NM1*87*2*HOSPITAL*****XX*1234567890~
N3*111 OVERHILL DRIVE~
N4*ANDOVER*MA*01810~
HL*2*1*22*0~
SBR*P*18** MassHealth*****MC~
NM1*IL*1*LAST*FIRST****MI*0101010101~
N3*230 1ST AVE~
N4*FALL RIVER*MA*02721~
DMG*D8*19511204*F~
NM1*PR*2*MEDICAID*****PI*DMA7384~
CLM*12225850*10157.05***11:A:1*N*A*Y*Y*********N~
DTP*096*TM*1130~
DTP*434*D8*20030116~
DTP*435*DT*200204091242~
CL1*2*1*01~
AMT*F3*100.00~
PWK*AS*EL***AC*123456~
REF*G1*MAA36169000029~
REF*F8*MAA36169000029~
REF*EA*MAA36169000029~
REF*G4*MAA36169000029~
NTE*ADD* TEST TEST~
HI*BK:29382~
HI*BF:12345*BJ:2989*BN:E9320~
HI*BR:8703:D8:20020327~
HI*BQ:8871:D8:20020328*BQ:8741:D8:20020401*BQ:8703:D8:20020401~
HI*BH:11:D8:20020330*BH:18:D8:19880430*BH:19:D8:19010101~
HI*BE:37:::4.00*BE:39:::4.00~
HI*BG:C5*BG:C6*BG:C5*BG:C5*BG:C5~
QTY*CA*4*DA~
HI*BI:11:RD8:20020330-20020402~
NM1*71*2*DOCTOR, ONE*****XX*1234567890~
PRV*AT*ZZ*103T00000X~

NM1*72*2*DOCTOR, TWO*****XX*1234567890~
PRV*OP*ZZ*103T00001X~

LX*1~
SV2*0150*HC:270:21*2753.00*UN*1~
DTP*435*DT*200204091242~
DTP*472*D8*20030201~

COB Claim

ISA*00* *00* *ZZ*0605638 *ZZ*DMA7384
*030306*1000*U*00401*000000049*0*P*:~
GS*HC*00181*112111001*20021106*1254*1*X*004010X096A1~
ST*837*0001~
BHT*0019*00*021119001*20021106*12542650*CH~
REF*87*004010X096A1~
NM1*41*2*XYZ SVC 81*****46*00189~
PER*IC*NOT LISTED*TE*8775679999~
NM1*40*2*MEDICAID*****46*112111001~
HL*1**20*1~
PRV*BI*ZZ*273R000999~
NM1*85*2*HEALTH XYZ HOSPITALS*****XX*1234567890~
N3*xx HOSPITAL ROAD~
N4*CITY*MA*014599004~
HL*2*1*22*0~
SBR*S*18*112111001******ZZ~
NM1*IL*1*xxx*yyy*S***MI*01346623999~
N3*54 xyz RD*W~
N4*CITY*MA*019992008~
DMG*D8*19990508*F~
NM1*PR*2*MEDICAID*****PI*112111001~
N3*600 WASHINGTON ST.~
N4*BOSTON*MA*02111~
CLM*5006935999*5370.1***11:A:1*Y**Y*Y*********Y~
DTP*096*TM*1100~
DTP*434*RD8*20021011-20021016~
DTP*435*DT*200210110100~
CL1*1*1*01~
REF*EA*3611889~
HI*BK:29630*BJ:29630~
HI*DR:430~
HI*BF:30019*BF:3019*BF:2449*BF:27800*BF:7245*BF:V148*BF:V145~
HI*BE:08:::2030~
HI*BG:C5*BG:65~
QTY*CA*5*DA~
QTY*LA*5*DA~
NM1*71*1*XYZ*J****XX*1234569990~
PRV*AT*ZZ*203B000999~
REF*1G*9995339~
SBR*P*18**XXX*****CI~
CAS*CO*A2*3533.63~
AMT*C4*1836.47~
AMT*B6*5370.1~
AMT*N1*1836.47~
AMT*AA*1836.47~
DMG*D8*19700508*F~
OI***Y***Y~
NM1*IL*1*XXX*YYY*S***MI*01346623999~
N3*54 XYZ RD*W~
N4*TOWN*MA*019992008~
NM1*PR*2*XYZ 81*****PI*001991~

COB Claim (cont)

N3*2 XYZ DRIVE~
N4*TOWN*ME*041999911~
DTP*573*D8*20021106~
REF*F8*1229630212~
NM1*71*1~
REF*1G*9939533~
NM1*72*1~
REF*1G*9993533~
LX*1~

SV2*0124**4400*UN*5*880~
SVD*00181*0**0124*5~
DTP*573*D8*20021106~
LX*2~
SV2*0250**2.76*UN*2~
SVD*00181*0**0250*2~
DTP*573*D8*20021106~
LX*3~
SV2*0259**410.34*UN*95~
SVD*00181*0**0259*95~
DTP*573*D8*20021106~
LX*4~
SV2*0300**557*UN*13~
SVD*00181*0**0300*13~
DTP*573*D8*20021106~
SE*74*0001~
GE*1*1~
IEA*1*000000049~

5.0 Version Table

Version	Date	Section/Pages	Description
	2/13/03	Entire document	Initial document created.
1.0	2/24/03	Entire document	Draft revised with updated MassHealth template.
1.1	3/3/03	Entire document	Draft revised after BA review.
1.2	4/8/03	Entire document	Draft revised after 837P edits were applied.
1.3	4/29/03	Entire document	Final revisions
1.4	5/03	Entire document	Draft revised after 837P edits applied.
1.5	6/03	Entire document	Draft version posted on Web.
1.6	6/30/03	Minor reformatting of entire document	Production version issued.
1.7	9/11/03	Entire document	Production version issued.
1.8	11/24/03	Links/text updated throughout document	Production version issued.
1.9	1/16/04	Revisions to pages 12, 15, 21	Additional hospice information added to Service Codes section and Provider Types Map.
2.0	5/18/04	Revisions to section 2.4	Production version issued.
2.1	7/02/04	Revision to page 11	Production version issued.
2.2	12/09/04	Update to Section 2.4 to reflect new Secure File Data information	Production version issued.
2.3	5/18/05	Updates to Sections 2.3, 2.5, 3.0, 3.7, 3.9, Appendix B and Appendix C to reflect TPA and 60-day noticing	Draft version issued. Production issue to follow.
2.4	10/05/05	Update to Sections 2.3 regarding zip file submissions, 2.5 regarding support contact information, 3.1 zip code update, 3.5 update to file naming conventions, 3.6 update to Detail Data tables, and 3.10 regarding support contact information	Production version issued.

Version	Date	Section/Pages	Description
2.5	4/12/06	Updates made to contact information and e-mail addresses throughout document. Update to Sections 2.1 and 3.5 to clarify language, and references to disk/CDs have been changed to "hard media." Updated Section 3.6 – Detail Data table, to reflect new OPD information. Updated notation in section 2.4 indicating a change in file naming conventions to require only submitter name and contact name. Updates made to Web links in Appendices B and C (Centers for Medicare & Medicaid Services (CMS).	Production version issued.
2.6	6/09/06	Minor updates made to Section 2.0, removed reference to ETPN and to Appendix A, revised contact information	Production version issued.
2.7	7/06	Typos resolved in Section 3.6 - Detail Data table, to read under Segment Name - 2300 DTP01, and under Element Name - Admission Hour and Day	Production version issued.
2.8	5/10/07	Updated applicable sections with NPI information	Production version issued.
2.9	9/25/07	Minor reformatting and editorial revisions of entire document	Production version issued.

Appendix A: Frequently Asked Questions

Q: How can I receive 997 functional acknowledgements for rejects at the claim level rather than the transaction-set level?

A: The 997 acknowledges rejection of all claims within the ST/SE boundary. The only way to receive a 997 rejection for each invalid claim is to submit your 837s with only one claim per transaction set.

Q: When applicable, should I use the place-of-service codes contained in the HIPAA Implementation Guide when submitting MassHealth paper claim forms too?

A: No, when submitting paper MassHealth claim forms requiring a place-of-service code, use the appropriate place-of-service code found in Subchapter 5 of your MassHealth provider manual.

Q: MassHealth has allowed outpatient departments that perform dental procedures to use the CDT codes and the CPT codes for oral surgery services. The 837D Implementation Guide states that CDT codes are the only service codes allowed when filing an electronic claim. What is the process for an outpatient department to submit claims for oral surgery services using a CPT code?

A: Outpatient departments should submit oral surgery claims with CPT codes using the 837P claim format, and all other dental services using the 837D format.

Q. Hospitals billing on the paper UB-04 claim form are required to enter revenue code 001 indicating "Total Charge" when submitting claims to MassHealth. Should this revenue code be entered on an 837I transaction?

A: No, revenue code 001 is not required on the 837I transaction, but continues to be required on the paper UB-04 claim form.

Q. If I identify other insurance that is not on file with MassHealth, how do I submit the claim?

A: Follow the standard process for any coordination of benefits (COB) claim. To obtain the MassHealth-assigned carrier code, cross-reference the insurance name with the appropriate carrier code in Appendix C of your provider manual, and enter the first three digits of the code on your 837 transaction. Concurrently, you should request that the MassHealth file be updated by sending all pertinent information to the appropriate address below.

MassHealth
Third Party Liability Unit
P.O. Box 9212
Chelsea, MA 02150
617-357-7604 (fax)

or

MassHealth
Medicare Unit
Schraffts Center
529 Main Street, 3rd Floor
Charlestown, MA 02129-1120
Fax: 617-886-8133

Do not send claim forms to these addresses.

Appendix B: Provider Types to Invoice Types Map

If you currently submit MassHealth invoice type	…and you are this provider type	…and you are billing this allowable service[1]	…then use this HIPAA transaction.
01	Acute inpatient hospital	Acute inpatient services	837I
01	Chronic inpatient hospital	Chronic inpatient services	837I
01	Psychiatric inpatient hospital	Psychiatric inpatient services	837I
01	Non-RFA semi-acute inpatient hospital	Non-RFA semi-acute inpatient services	837I
01	Intensive residential treatment program.	Intensive residential treatment program services	837I
03	Non-RFA semi-acute outpatient hospital	Non-RFA semi-acute outpatient services	837I
03	Acute outpatient hospital	Acute outpatient services	837I
03	Hospital licensed health center	Hospital licensed health center services	837I
03	Chronic outpatient hospital	Chronic outpatient services	837I
03	Psychiatric outpatient hospital	Psychiatric outpatient services	837I
09	Community health center (CHC) [2]	Home health services	837I
09	Home health agency[2]	Home health services	837I
09	Hospice[3]	Hospice services	837I
10	Nursing facility[2]	Nursing facility services	837I
10	ICF-MR state school[2]	ICF-MR services	837I
10	Rest home[2]	Rest home services	837I

[1] Please consult Subchapters 5 and 6 of your MassHealth provider manual for information on acceptable revenue and service codes.

[2] Providers who previously submitted claims using the MassHealth proprietary electronic formats for the no. 9 and no. 10 claim forms should consult the National Uniform Billing Committee (NUBC) code data for acceptable revenue codes.

[3] Hospice providers must use only those revenue codes found of the list of acceptable codes issued by MassHealth for all claims with dates of service on and after January 1, 2004. *The list of acceptable revenue codes was mailed to all hospice providers via Transmittal Letter HOS-12* (December 2003).

Appendix C: Links to Online HIPAA Resources

The following is a list of online resources that may be helpful.

Accredited Standards Committee (ASC X12)

- ASC X12 develops and maintains standards for inter-industry electronic interchange of business transactions. www.x12.org

American Hospital Association Central Office on ICD-9-CM (AHA)

- This site is a resource for the International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) codes, used in medical transcription and billing, and for Level I HCPCS. www.ahacentraloffice.org

American Medical Association (AMA)

- This site is a resource for the Current Procedural Terminology 4th Edition codes (CPT-4). The AMA copyrights the CPT codes. www.ama-assn.org

Association for Electronic Healthcare Transactions (AFEHCT)

- AFEHCT is a health-care association dedicated to promoting the interchange of electronic health-care information. www.afehct.org

Centers for Medicare & Medicaid Services (CMS)

- CMS, formerly known as HCFA, is the unit within HHS that administers the Medicare and Medicaid programs. CMS provides the Electronic Healthcare Transactions and Code Sets Model Compliance Plan on its Web site at www.cms.hhs.gov.
- This site is the resource for information related to the Healthcare Common Procedure Coding System (HCPCS). www.cms.hhs.gov/MedHCPCSGenInfo/

Designated Standard Maintenance Organizations (DSMO)

- This site is a resource for information about the standard-setting organizations and transaction change request system. www.hipaa-dsmo.org

Health Level Seven (HL7)

- HL7 is one of several ANSI-accredited Standards Development Organizations (SDO), and is responsible for clinical and administrative data standards. www.hl7.org

MassHealth

- The MassHealth Web site assists providers with HIPAA billing and policy questions, as well as provider enrollment support. www.mass.gov/masshealth

National Council of Prescription Drug Programs (NCPDP)

- The NCPDP is the standards and codes development organization for pharmacy. www.ncpdp.org

National Uniform Billing Committee (NUBC)

- NUBC is affiliated with the American Hospital Association and develops standards for institutional claims. www.nubc.org

National Uniform Claim Committee (NUCC)

- NUCC is affiliated with the American Medical Association. It develops and maintains a standardized data set for use by the noninstitutional health-care organizations to transmit claims and encounter information. NUCC maintains the national provider taxonomy. www.nucc.org

Office for Civil Rights (OCR)

- OCR is the office within the Department of Health and Human Services responsible for enforcing the Privacy Rule under HIPAA. www.hhs.gov/ocr/hipaa

United States Department of Health and Human Services (DHHS)

- The DHHS Web site is a resource for the Notice of Proposed Rule Making, rules, and other information about HIPAA. www.aspe.hhs.gov/admnsimp

Washington Publishing Company (WPC)

- WPC is a resource for HIPAA-required transaction implementation guides and code sets. www.wpc-edi.com/HIPAA

Workgroup for Electronic Data Interchange (WEDI)

- WEDI is a workgroup dedicated to improving health-care through electronic commerce, which includes the Strategic National Implementation Process (SNIP) for complying with the administrative-simplification provisions of HIPAA. www.wedi.org